Montana Medicaid Claim Jumper

Emergency Department Claims

The Department is currently working on an Administrative Rule of Montana (ARM) change that will allow two additional provisions to be reimbursed in Emergency Department (ED) claims. Claims with CPT code 90801 and claims for children ages 0-2 on weeknights and weekends will reimburse under current methodology even if the diagnosis code is not on the Department's Emergency Diagnosis list (the diagnosis must still be a covered diagnosis). Non-covered services and services for prescriptions or supplies only will still not be reimbursed. These claims currently receive only a screening and evaluation fee if the diagnosis is not on the Emergency Diagnosis List.

Weeknights will be defined as 6 p.m. until 8 a.m. on Monday, Tuesday, Wednesday and Thursday. Weekends will be defined as 6 p.m. Friday evening until 8 a.m. Monday morning. This change is scheduled to be effective January 1, 2005. In the meantime, ED claims determined by the medical professional to be emergent, but the diagnosis is not on the Emergency Diagnosis List, may be sent to Mountain-Pacific Quality Health Foundation (MPQHF) for review. The claims must have been processed by ACS prior to being sent to MPQHF.

Claims for critical access hospital and exempt hospital services are exempt from the Emergency Diagnosis List. However, physician and other provider services (even when performed in a CAH or exempt hospital) are not exempt from the Emergency Diagnosis List.

Professional claims for ED services with dates of service August 1, 2003 to May 10, 2004 are scheduled to be mass adjusted in July to reimburse claims billed with an emergent diagnosis code. Because the claims system could not accurately process professional ED claims until May, the previously reimbursed claims that did not always have an emergent diagnosis code will be adjusted. Remember, PASSPORT authorization is no longer required for ED services effective August 1, 2003.

Avoiding Returned Claims

Claims are "RTPed" (returned to provider) when they don't pass an initial screening. Incoming claims are screened to ensure that the basic information required to process the claim is entered on the claim in the correct field, such as provider ID numbers, signatures, billed date, etc. This screening is performed as a courtesy to providers, since it allows errors to be identified and corrected quickly. RTPed claims are always sent with an explanation of why they are being returned. To avoid returned documents, providers are encouraged to double-check that claims are filled out accurately and completely.

Other submitted documents, such as enrollment applications, are also subject to screening and incomplete documents are returned to the provider. If you have any questions about how to fill out enrollment applications, address change forms, direct deposit forms, etc., please contact provider relations before submitting the forms (see Key Contacts on back page of this newsletter).

Checking Benefit Limits With Provider Relations Unit

Providers may contact provider relations to inquire about the status of benefit limits, such as limits on mental health services. However, providers should keep in mind that PR staff can only access information regarding claims history, i.e. services that have already been billed and adjudicated.

Information regarding services that have been rendered, but not yet billed, is not available to PR staff. With this in mind, providers should use claims history information relating to benefit limits as a guideline only. The only definitive information PR staff can give is when a benefit limit has been reached or exceeded and thus can be confirmed in claims history.

Providers Respond Positively To Team Care Program

Team Care (TC), Medicaid's new utilization management and education program, officially began this month with the enrollment of 95 clients into the program.

In June, the Department identified the initial clients for program enrollment and sent letters to their respective providers asking for "validation" of inappropriate medical use. Providers completed the validation process by reporting to DPHHS all clients NOT valid for enrollment; all other clients were automatically enrolled.

The Managed Care Bureau has received over 30 positive responses from providers. Many providers who disenrolled clients also provided recommendations or "referrals" for other potential enrollees into the program. Referrals can be made by using the "Team Care Provider Referral Fax" found on the Team Care page at *www.mtmedicaid.org* or by calling the Managed Care Bureau at 444-1518.

For questions or concerns regarding Team Care, visit the Team Care page at *www.mtmedicaid.org* or call Tedd Weldon in the Managed Care Bureau at (406) 444-1518, or email him at teweldon@state.mt.us.

Team Care FAQs

Q: Can I remove a client once they've been enrolled in Team Care?

A: Yes. Providers may disenroll clients from Team Care at any time by contacting the Managed Care Bureau at (406) 444-1518.

Q: Have clients received information regarding Team Care?

A: Yes. Last month, TC clients received materials which explained the program and informed them of their requirements to enroll in PASSPORT, select a single primary care provider (PCP), select a single pharmacy, and call the Nurse First Advice Line prior to accessing Medicaid payable health care – except in emergent care situations.

Q: If the client does not call Nurse First prior to a PCP visit, does Medicaid pay?

A: Yes. Though providers are encouraged to require clients to call Nurse First prior to accessing care, Medicaid will pay, providing that the PCP is the client's assigned PCP, or has received an appropriate "referral."

Q: Where does liability rest when a client phones Nurse First for a care recommendation?

A: McKesson's professional liability insurance covers losses caused by an act, error or omission in rendering professional services. Taking calls from Medicaid clients is part of their professional liability

Electronic Claims Submission For Nursing Facilities

Nursing facility claims are currently processed using Turn-Around Document Reports (TADs) and MA-3 claim forms. Until recently, there was no method allowing nursing facilities to submit claims electronically. However, ACS' new electronic claims submission software, WINASAP2003, is capable of generating and submitting HIPAA-compliant nursing facility claims.

There are numerous benefits for billing electronically. Claims for the previous month's services can be submitted on the first of the month and are received for processing in minutes, thus ensuring the claims are paid on the first payment cycle of the month. Potential problems, such as poor quality faxes, delivery delays, and opportunities for keying errors in processing, are eliminated. Even claims for ancillary services provided by the nursing facility can be submitted electronically using the easy-to-learn WINASAP2003 software.

This service is absolutely free. The software is free and claims are sent via a toll-free phone number. All that is needed to get started is a PC and standard phone line.

The free software and enrollment forms can be downloaded at *www.acs-gcro.com* (or through a link at *www.mtmedicaid.org*). Interested providers are encouraged to initiate the enrollment process as soon as possible. In addition, upon request, ACS Provider Relations will conduct small group and one-on-one trainings in your area or at your facility. To schedule training, please call Michael Mahoney at (406) 457-9532 or Maria Rogne at (406) 457-9531.

Recent Publications

The following are brief summaries of publications regarding recent program policy changes. For details and further instructions, download the complete notice from the Provider Information website at *www.mtmedicaid.org*. Select "Resources by Provider Type" for a list of resources specific to your provider type. If you cannot access the information, contact provider relations at (800) 624-3958 or (406) 442-1837 in Helena or out-of-state.

Notices		
Date Posted	*Provider Type(s)*	*Description*
06/28/04	**Pharmacy**	Coordination of Benefits (06/15/04)
07/08/04	**Optician, Optometric, Eyeglasses**	New Prescriptions for Eyeglasses (07/01/04)
Manuals/Replacement Pages		
06/23/04	**Home Infusion Therapy**	New Manual (06/04)
07/14/04	**Hospice**	New Manual (07/04)

The Next Five Top Denial Reasons (And How To Avoid Them)

In last month's *Claim Jumper,* we listed the top five reasons why Medicaid claims are denied. Here are reasons six through 10 to complete the top ten. Providers are encouraged to review these denial reasons and develop procedures to avoid these common errors.

6. Client has Medicare Part B and it is a Medicare-covered service. Medicare must process this claim prior to Medicaid. If Medicare denies payment, the claim, with the Medicare EOB attached, can be submitted for Medicaid processing. Note: if Medicare denies for medical necessity, Medicaid will follow suit.

7. More than one surgical procedure on the same day. This is a similar situation to #10, global surgery period. The first surgical procedure processed for the date of service will be considered the principal procedure and is reimbursed as such. (This is usually the first line of the initial claim for the date of service.) Appropriate modifiers can be used to identify subsequent procedures, which will be reimbursed at a reduced rate.

8. Incorrect client ID number. Even the best of us makes an occasional typo. The only remedy to this common reason for denial is to carefully check all the information in your claims prior to submission, especially the (long) numbers like client IDs.

9. Timely filing. Claims can be submitted for processing up to 12 months from the *date of service*. Most claims beyond this time frame cannot be considered for reimbursement. When a claim is denied within the timely filing period, it does not "re-set" the 12 month time frame. If an ACS error caused undue delay in processing the claim, providers may appeal the claim to the Department. Also, if a claim is approaching the timely filing deadline, please contact ACS provider relations to expedite processing. More information regarding timely filing will appear in the next issue of the *Claim Jumper.*

10. Service provided within the global surgery period. This can occur when providers in the same group practice with the same specialty provide services that post against each other. For example, an E&M service or surgical procedure is billed within the global period of another procedure. Appropriate modifiers can be used to indicate that the services/procedures are unrelated. Otherwise, it is assumed that the services have already been paid under the global reimbursement.

Dishonorable mentions: Other common denial reasons include: missing or incorrect PASSPORT number; incorrect or invalid HCPCS or revenue code; and incorrect or invalid prior authorization number.

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Key Contacts

Provider Information website http://www.mtmedicaid.org
ACS EDI Gateway Website http://www.acs-gcro.com
ACS EDI Help Desk (800) 987-6719
Provider Relations (800) 624-3958 (in Montana)
(406) 442-1837 (Helena & out-of-state)
(406) 442-4402 fax
TPL (800) 624-3958 (in Montana)
(406) 443-1365 (Helena & out-of-state)
(406) 442-0357 fax
Direct Deposit Arrangements (406) 444-5283
Verify Client Eligibility
FAXBACK (800) 714-0075
Automated Voice Response (AVR) (800) 714-0060
Point-of-sale Help Desk for Pharmacy Claims (800) 365-4944
PASSPORT (800) 624-3958
Prior Authorization
DMEOPS (406) 444-0190
Mountain-Pacific Quality Health Foundation (800) 262-1545
First Health (800) 770-3084
Transportation (800) 292-7114
Prescriptions (800) 395-7961

Provider Relations
P.O. Box 4936
Helena, MT 59604

Claims Processing
P.O. Box 8000
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Third Party Liability
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